No. 300
10-48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 16 1950

State File No. 2617
117

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY 2226
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis,
d. STREET ADDRESS (If rural, give location) 2240a Randolph St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Irene		Hubbard	Jan.	3	1950

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Colored	Married	August 7, 1900	49	4	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS/INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		St. Louis, Missouri	U.S. A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
James Giles	Harriett Burke	Carloo Hubbard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
No.		Mrs. Vernita Jefferson 2240a Randolph

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		83

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY Ooccur?
m.		331X

22. *I hereby certify that I attended the deceased from* 9-26, 19 49, *to* 1-3, 19 50, *that I last saw the deceased alive on* 1-3, 19 50, *and that death occurred at* 11:10am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen J. Hedrick M.D.	2601 N Whittier St	1-4-50

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jan. 9, 1950	Greenwood Cemetery	St. Louis County, Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JAN 6 1950	J. B. Lasater	E. B. Bonce 1221 N. Grand

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Clarence Crosson

Licensed Embalmer No. 4755

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.